Regional Workgroup Minutes

August 30, 2011
10:00 am to 3:15 pm
Polk County River Place
2309 Euclid Avenue, Des Moines, IA

MINUTES

Attendance

Workgroup Members: Jane Arnold, Robert Brownell, Tom Eachus, Lori Elam, Jack Guenthner, David Hudson, Sarah Kaufman, Bob Lincoln, Charles Palmer, Sally Stutsman, Suzanne Watson, Jack Willey, and Joel Wulf (sitting in for Donna Harvey)

Legislative Representation: Renee Schulte, State Representative, House District 37 (Linn County) and Co-chair of the Legislative Interim Committee on MHDS Redesign; Jack Hatch, State Senator, District 33 (Polk County) and Co-chair of the Legislative Interim Committee on MHDS Redesign

Facilitator: Steve Day, Technical Assistance Collaborative (TAC)

DHS Staff: Theresa Armstrong, Connie Fanselow, Julie Jetter, Brian Wines

Other Attendees:

Deb Albrecht	Berryhill Center, Fort Dodge
Kristen Artley	Johnson County Mental Health & Disability Services
Bob Bacon	Center for Disabilities and Development (CDD)
Julie Bak	Mahaska County CPC Administrator
Jennifer Bauer	Candeo
Kris Bell	Senate Democratic Caucus
James Bremhorst	Magellan Health
Josh Bronsink	Senate Republican Caucus
Amy Campbell	Multi-client lobbyist
Dawn Clark	Wapello County
DeAnn Decker	Iowa Department of Public Health (IDPH)
Michelle De La Riva	The Richmond Center, Ames
Diane Diamond	DHS Targeted Case Management
Shannon Evers	Eyerly Ball CMHC/United Way
Glenda Farrier	CASS Incorporated

Other Attendees (continued):

Patty Funaro	Legislative Services Agency
Sarah Dixon Gale	Iowa Primary Care Association
Jessica Harder	Davis Brown Law Firm
Linda Hinton	Iowa State Association of Counties (ISAC)
Sandi Hurtado-Peters	Department of Management (DOM)
Ken Hyndman	Des Moines County CPC Administrator
Sandra Mireles	Winnebago-Hancock-Worth County Social Services
Mary Beth Nelson	Cerro Gordo County Targeted Case Mgmt.
Brice Oakley	Iowa Alliance of CMHCs
Liz O'Hara	Center for Disabilities and Development (CDD)
Kelley Pennington	Magellan Health
John Pollak	Legislative Services Agency (LSA)
Karen Riggle	Van Buren County CPC Administrator
Ann Riley	Center for Disabilities and Development (CDD)
Joe Sample	Iowa Department on Aging (IDA)
Angie Doyle Scar	Iowa Department of Public Health (IDPH)
Kim Scorza	Seasons Center
Patrick Schmitz	Plains Area Mental Health Center
Deborah Schultz	Jones County CPC Administrator
Rik Shannon	Iowa Developmental Disabilities Council
Deb Eckerman Slack	ISAC County Case Management
Julie Smith	Iowa Health System
Chris Sparks	Exceptional Persons Inc.
Tom Stanberry	Davis Brown Law Firm
Mikki Stier	Broadlawns Medical Center
Bob Thacker	Northeast Iowa Behavioral Health
Deanna Triplett	Iowa Behavioral Health Association
Jennifer Vitko	Wapello County CPC Administrator
Karen Walters-Crammond	Polk County Health Services
Dion Williams	Systems Unlimited
Ryanne Wood	Lee County CPC Administrator
Ben Woodworth	Iowa Association of Community Providers (IACP)

Agenda

Agenda Topics:

- Introductory remarks
- Presentations on current regional activities:
    - Bob Lincoln, County Social Services
    - Jack Guenthner, North West Iowa Contracting Consortium
    - Sarah Kaufman, Southeast Iowa Mental Health and Disability Services
    - Joel Wulf and Joe Sample, Aging & Disability Resource Centers
- Recap of Meeting One and discussion points on regional approaches
- Group discussion of criteria for formation of regions
- Group discussion of governance options

- Group discussion of regional service planning
- Next Steps
- Meeting Summary
- Public Comment

INTRODUCTORY REMARKS BY CHAIR CHUCK PALMER:

New MHDS Administrator hired:

- Rick Shults has been named the new Administrator for the Division of Mental Health and Disability Services and will be starting September 19, 2011.
- He has been serving as director of mental health services in Kansas.
- He has a strong background in mental health and disability services and is committed to working with the consumer community in service development and delivery.
- The redesign effort was a factor in his decision to come to Iowa.
- He is anxious to join the process.
- The work Karalyn Kuhns has done as Interim Administrator in addition to her regular duties is greatly appreciated.
- Karalyn will continue to play an important role in the redesign and the Division.

More consumer and family input into Redesign:

- Director Palmer has been working with statewide advocacy groups to put together a tentative schedule for four public meetings to gather input.
- Expected to be scheduled on Fridays in larger communities around the state.
- Will be announcing where and when those will be held next week.
- Want leaders of advocacy groups to come to meetings and share their input.
- Hope to have good participation.

Goals for today's meeting:

- Narrow discussions and look for areas of consensus.
- Share some information to assist everyone in understanding the big picture and the Iowa-specific issues.
- Keep in mind the legislative intent.
- Talk about the criteria for regions contained in Senate File 525.
- Reach consensus on some key aspects of regional criteria.

PRESENTATIONS ON CURRENT REGIONAL ACTIVITIES

Four different types of regional collaboratives from formal to informal, and each at different stages of development talked about their experiences and how they have dealt with challenging issues:

Bob Lincoln, County Social Services: County Social Services (CSS) is comprised of Butler, Cerro Gordo, Mitchell, Floyd, Black Hawk, and Wright counties.

The legislative intent of SF 525 contained three major points:

1. Shifting Medicaid costs from the counties to the State.
2. Replacing legal settlement.
3. Developing regional administration.

Shifting Medicaid costs from the counties to the State:

- Transactional frictions now occur.
- Looked at what was invested in reviewing Medicaid bills that come back to the county after the state has paid the provider.
- DHS has worked hard to improve the Medicaid billing process.
- Sampled about six months looking for overpayment that wasn't caught by Medicaid and found only very nominal amounts (i.e. $200 out of $1 million in claims).
- Don't think there is much value in that considering the administrative cost.
- That is a transactional friction that could be eliminated.
- Might lose some data coordination.
- Think it would reduce region's operating cost by $15,000 to $20,000.
- Could probably eliminate some redundancy between ISIS (Individualized Services Information System) and CSN (Community Service Network).

Shared CSS projected management (unaudited) figures:

- Expenditures were broken down into Medicaid match and non-Medicaid (100 percent county).
- FY (fiscal year) 2011 spent $13.4 million for the non-federal share of Medicaid.
- $14.9 million dollars was received from the State.
- All counties in the regional are at maximum maintenance of effort for property tax levies, which generate $9.6 million.
- They purchased $11.1 million in non-Medicaid services.
- Without the State Medicaid money or the obligation to pay the non-federal share that would leave a shortfall of about $1.5 million, and program adjustments could be made to offset that amount.
- Projection for FY 2012 shows the impact of the lost of the federal ARRA (American Recovery and Reinvestment Act) money.
- Medicaid match expected to grow to $15 million, which would overtake the State allocation.

Replacing legal settlement:

- If Medicaid is covered by the State, the impact of legal settlement is dramatically reduced.
- Most of the 100% county dollars that go outside the catchment area are currently going to people in residential placements.
- That situation would not change with moving from legal settlement to residency.
- This is the time to end legal settlement because it will have very little impact if the non-federal Medicaid costs shift to the State.
- State cases can be identified and absorbed rather easily.

Developing regional administration:

- Trying to identify crisis beds.
- Using a county facility to develop a nursing home for persons with persistent mental illness.
- Don't yet have rules for a sub-acute level of care, but anticipate they can be met.
- Working with hospitals on the civil commitment process and alternative levels of care.
- Children's services – one of few county management plans to include reimbursement for Toledo or for shelter care if a child meets the criteria
- Creates a greater opportunity for the county to address children's needs.
- Initiating a collaboration with the Hawkeye Area Agency on Aging (AAA).
- Vested in the Aging and Disability Resource Center (ADRC) and the concept of one phone call to initiate services.

Summary:

- Tried to preserve county offices.
- To provide access and service coordination to people in the community.
- Have one fund.
- Butler County serves as the fiscal agent for the six counties.
- One governing board with one Board of Supervisor representative from each county.
- One management plan that all six counties use.
- A single number to call as an important element in providing access.
- The plan includes a regional planning committee, but that is the one piece that has never gotten working logistically; they utilize local consumer liaisons.
- Total population in the CSS is about 230,000.

What brought the members together?

- Initiated by county supervisors.
- Started the conversation with 12 counties at the table.
- There was political buy-in at the local level.
- It was about the counties deciding they wanted to respond to the State's request for more collaboration.
- It began with the concept of sharing an administrator.
- It took about 15 years for the group to fully form.
- They identified shared needs and opportunities while figuring out how to preserve what was most important to them as individual counties.
- The decision made to form one board and one pot of money.

How is the money managed?

- All state allocation comes into the collective.
- Each county continues to have a Fund 10 into which they draw their individual property tax dollars.
- They operate all the administrative costs for that county out of their fund and it is replenished from the collective account; that process captures the expenditures.

- This year will be the first year they will have one annual fiscal report generated for all five counties.
- The other funds serve as revolving funds for operating costs.

Jack Guenthner, North West Iowa Contracting Consortium

- NICC is comprised of Cherokee, Clay, Lyon, O'Brien, Osceola, Palo Alto, Plymouth, Sioux, and Woodbury counties.
- Formed in 1999 for the purpose of engaging in multi-county contract formation and negotiation.
- To save county and provider resources and establish a consistent rate setting and contract review process.
- Formal 28E agreement signed in 2000.
- Governing board of nine members, one representing each county.
- Board meets quarterly.
- They chose not to pool funds.
- Maintain their own county management plans.
- Cherokee County serves as the fiscal agent.
- Board members and advisory members form two contract negotiation teams.
- Teams meet with providers at the end of the year and negotiate rates for the upcoming year.
- All members abide by the same rates and have a common contract.
- Each county has its own CPC, a separate Fund 10, and separate property tax dollars.
- Providers are required to use a CRIS (County Rate Information System) format for financial and statistical reporting.

Sarah Kaufman, Southeast Iowa Mental Health and Disability Services

- Serving Des Moines, Henry Keokuk, Lee, Louisa, Muscatine, Van Buren, and Washington counties.
- "One-plan" work began in August 2009.
- One County plan needed updating.
- Nearby counties had developed a joint management plan.
- Attempt to simplify things for consumers and providers.
- Each county is getting more and more familiar with the operations of neighboring counties because of changes in residency rules.
- It made sense to start working together in planning.
- The intent is eventually to operate under one plan.
- To share best practice approaches in access, authorization, service delivery, and improve outcomes for consumers, service providers, and counties.
- Looked at boundaries – all eight counties share borders.
- Des Moines County and Lee County have critical care hospitals.
- Henry County has the Mt. Pleasant MHI.
- Having a partnership helps in addressing problems.
- Talked about what counties would be a good match.

- Decided going west worked best.
- A group of seven counties to the west had come together to do a single plan (Appanoose, Davis, Jefferson, Lucas, Monroe, Wapello, and Wayne).
- That group had also thought about reaching out to the counties to the east.
- That creates a potential for growth.
- Question: If Muscatine would remain or if they would fit better with Scott and other counties?
- Counties use similar providers.
- Access points would remain about the same.
- Contracting is similar; all use CRIS system.
- One county would be the lead contractor.
- All would meet together with providers instead of holding separate meetings.
- Case management is an issue to be addressed:
    - One county uses DHS case management.
    - Two have their own county case management.
    - Four use private case management exclusively.
    - One uses mixed county and private case management.
- They have not shared funding.
- If it is decided there should be a single CPC, the current CPCs would apply and compete for that role.
- Supervisors would make the selection.
- Developing one plan would be a good first step in moving to do business differently.
- Wanted to be proactive in adopting a regional philosophy.
- Looked at developing specialty skills:
    - a contracting liaison
    - a case management director
    - community stakeholder/community supports liaison
    - information technology
    - intake coordinator
- Looking at changes that may be needed in quality assurance, appeals process, business practices, policies and procedures, personnel, involuntary commitment procedures.

How far along is the process?

- Current plan is to maintain the individual CPCs and separate funding.
- Continue working with boards of supervisors on a new way of thinking.
- No formal governance structure has been formed.
- Know that the seven counties want to be a region.
- The eight county population is about 191,000.
- Have a good mix of city and rural and a wide variety of services.
- Have an MHI and two hospitals with inpatient psychiatric units.
- Only Washington County is served by a community mental health center.
- Have federally qualified health care centers.
- If the seven western counties were added the population total would be about 240,000 without Muscatine County or about 280,000 with Muscatine County.

- The boards of supervisors have all given the ok to start working on it.
- County attorneys and stakeholders still have to approve the plan and they held a joint seven county stakeholder meeting in June.
- Have done some common contracting.
- Felt adopting a management plan that is comprehensive across all counties is the first big step.

Joel Wulf and Joe Sample, Aging & Disability Resource Centers (ADRCs)

Consolidation of Area Agencies on Aging:

- House File 45 instructed the Iowa Department on Aging to submit a plan to the General Assembly by December of this year to reduce the number of Area Agencies on Aging (AAAs) from 13 to 5.
- Over the summer Director Harvey chaired meetings on consolidation in each of the 16 service areas.
- Over 600 people participated and provided input.
- On August 16 IDA's commission voted to consolidate into five AAA regions.
- 12 of 13 existing AAAs have voluntarily asked to merge into the new regions, only Burlington has declined.
- IDA is in the process of clarifying if an RFP process is needed and how they should move forward.
- Administrative rules will be promulgated in preparation.
- Will have the plan to the General Assembly in December.

Discussion:

- Several models were considered for AAA consolidation.
- Looked at funding formulas and originally created six regions.
- The Older Americans Act requires weighted funding to certain populations.
- Looked at best balance for rural and urban counties and made some changes to achieve more equitable results for all areas.
- The AAAs themselves proposed the five-region model.
- Process involved a lot of local input and voluntary agreement,
- AAAs were asked to submit a voluntary plan and all 13 were unable to do that.
- This plan is based on a voluntary plan of 12 of the AAAs.
- Imposed some parameters at the state level and exercised some administrative discretion in making a plan come together.
- In the large region in the western part of the state there are already regional presences and those will remain for local access.
- The incentive was to cut administrative costs in order to survive and to redirect any savings possible to services.
- The focus has been on what makes sense geographically.
- Five regions merged into Region 1; three regions merged into Region 2; Regions 3 and 4 remained as they were; three regions merged into Region 5; and Area 16 (Burlington, four counties) declined to merge.
- Talking to the Attorney General's Office to determine next steps.

- May need to go through and RFP process; that would open up bidding to other organizations beyond the existing AAAs.
- Still determining how the Burlington area will be incorporated.
- Hope to have the plan ready to submit to the General Assembly by late fall.
- Plan will outline what they would like to do and what it would take to do it.
- AAAs are 501(c)(3) organizations and Iowa Code 8F would apply.
- The AAA board membership would need to reflect the new regions.

Aging and Disability Resource Centers:

- ADRCs are a concept from CMS (Centers on Medicare and Medicaid) and the Administration on Aging.
- Model for integration of services and a “no wrong door” approach.
- Different approaches, including virtual ADRCs and localized approaches.
- Iowa is looking at a blended approach.
- There are currently two pilot sights in Waterloo and Cedar Rapids working to develop a model that is replicable statewide.

ADRC Core Elements:

1. Consumers and Stakeholders
2. Information/Referral and Access
3. Options Counseling
4. Eligibility Determination
5. Transition Support
6. Quality Assurance

Consumers and Stakeholders:

- Building a legitimate partnership between the aging and disability communities.
- A coordinating agency to prevent fragmentation.
- Consumers sit on advisory boards.
- Representation by consumer advocates and service providers.

Information/Referral and Access:

- Currently ADRC is working with Compass, 211, and Family Caregiver database to provide I&R services.
- To link consumers to public and private supports.
- There is also work underway to integrate the three distinct services into one common database.
- Promote long-term service and support options.
- Focus on underserved populations.

Options Counseling:

- To assess needs and counsel on service and support options.
- Consumer driven decision making.
- Still in its infancy; work being done on development of national standards.
- Looking at it becoming a Dept. of Labor occupation.
- Envisioned as a bridge service between I&R and case management.

Eligibility Determination:

- No wrong door concept.
- Options counselor can assist in applying for preferred options.
- Confirms eligibility for public goods and services through single point of entry.
- Opportunity to streamline eligibility criteria.
- Single intake/screening/application process.

Transition Support:

- Person-centered transition planning to link with community-based services.
- Afford Care Act opportunities.
- CMS has approved care transition models.
- Provides for holistic care.
- Helps avoid unnecessary re-admissions and associated expense.
- Helps to improve consumer choice.

Quality Assurance:

- Measurable outcomes across systems.
- Consumer and stakeholder assessment of quality.
- Develop cost-avoidance models for government, local services, and consumers.

Discussion:

- ADRC concept is inclusive of disability and aging populations.
- The aging network must partner with the disability community to be fully functional.
- Now at the very beginning of conversations on how IDA and DHS can collaborate.
- Further discussion on that potential continues.
- There are federal criteria with flexibility in how states form their ADRCs.
- Most states have established some pieces of the ADRC.
- New Jersey is looked at as having the most complete ADRC and it has taken them 30 years to get there.
- Iowa submitted a five-year plan to achieve a functioning ADRC by 2015.
- It is likely that plan will be reviewed and amended as it moves forward.
- Want a creative design that really fits our state.
- The statutory responsibility is with IDA under Iowa Code Chapter 231.
- ADRCs are designated by the State and do not currently have formal governing boards.
- By contract, AAAs must have a local governing board.
- One possibility is that a regional board could contract with an ADRC.
- Administrative rules are in the development process.
- The cost of having a live social worker available on the phone could easily be shared.
- The ADRC would have access to information systems, 24-hour call centers, information and referral services and a no wrong door approach.
- It would be able to serve all populations.

- Opportunity for flexibility and creativity; a “social service first-responder” concept.
- ADRCs are not currently involved in provider negotiations or contracting; those are AAA functions.

RECAP OF MEETING ONE AND DISCUSSION POINTS ON REGIONAL APPROACHES

Take-away lessons:

- There are a lot of things you can do.
- Groups can grow organically to accomplish similar ends.
- It really helps to have a mandate and some direction to create a clear understanding that something will happen.
- A framework where there are policies and a push to get it done is needed.
- Without that, people aren’t always motivated to make the changes.

Thinking differently:

- Consider business functions – does it really matter where they happen?
- Have you recognized cost savings?
- There is a benefit to doing things better, but it may not be easy to measure.
- It makes sense to allow natural relationships to be built first and then if there are pockets of resistance, deal with that separately.
- Be intentional about keeping administrative costs down (CSS administrative costs are 1.5% of total budget).
- You can centralize functions without moving people and offices.
- Different functions handled in different county offices can reduce duplication.

Discussion points for arriving at criteria:

Getting to clear recommendations on what criteria should be used for forming regions

- What should regions look like?
- About how many should there be?
- How big they should be?
- What must they have to be a region?
- What will the regions do?

Discussion:

- Regions will have to continue to work with other entities and with each other.
- Don’t want to create another type of transactional friction.
- Regions by themselves are not the solution to any problem.
- They won’t solve problems of scarce service resources, dealing with a variety of providers, etc.
- Regions are a tool to be used.
- Talking about dynamic strategies to try to find the most efficient use of resources and ease of access for people.
- What matters is the face to face contact between the system and the people in the community; not where the bills get paid or the back office work gets done.

- Not every region would have to have every function; they could contract for it.
- Does the regional design meet the test of adding value or does it create new problems?
- Recommend criteria that will drive the decision making process on how regions come together.
- Will have to deal with the issue of counties who don't want to play.
- It makes sense to allow counties to come together voluntarily unless they are unwilling to do so.
- Review the summary of benefits of regions in the issue paper on the website.

Remarks on legislative intent by Senator Jack Hatch:

- Regions are intended to be a creature of the counties.
- The counties should prescribe their regional territory.
- Counties should have the ultimate authority in how they come together and organize.
- Keep in mind what you are trying to accomplish.

Questions/Issues:

- How organic should the process be?
- How much time should they have to form?
- Tension between natural selection and fixed criteria.
- What to do if some counties won't play?
- Not so concerned about the number of regions; more concerned about the geography.
- How to handle financing at the regional level?
- Do members have to be a county?
- Radius from urban centers?

GROUP DISCUSSION OF CRITERIA FOR FORMATION OF REGIONS

- Senate File 525 sets out some criteria.
- Transportation is big concern in rural areas.
- If regions get too big, the availability of services can create problems.
- There are already natural groups working together both formally and informally.
- Early on the legislature looked at organizing around urban areas for reasons of capacity. They decided to back off that structure and went to the criteria in SF 525.
- Counties should have opportunity to form naturally.
- North Carolina went through a 20-year organic process.
- It took a final push from the state to force smaller regions; within 2 or 3 months groups were falling into place.
- Not unlike what has been happening with the AAAs here in Iowa.
- Examine capacity, core services, provider availability, and risk management.
- Fiducially responsibilities and risk need to go together
- Do regions necessarily have to do the back office functions?
- Can that be separate from the delivery of services?

- Once criteria are determined, natural regions may emerge.
- Develop a set of objective criteria to test whether a natural group meets what it needs to be become a region.
- Natural tension between clear criteria and being respectful of natural choices.
- Too much flexibility allows counties to step away from the table.
- Legislative criteria includes inpatient psychiatric services and CMHC or FQHC.

Functions of regions:

1. Development of a regional service plan
2. Designation of access points
3. Service authorization
4. Designation of targeted case management
5. Contracting with providers/paying providers
6. Managing money
7. Quality management/quality improvement

Southeast Iowa Mental Health and Disability Services survey:

- Sarah Kaufman shared results of an MHDD System Survey from June stakeholder meeting for eight county plan.
- 179 attended; 78 responded to the survey.
- 82% preferred to access services through county government.
- 35% thought funding should be the responsibility of the county; 27% state; 25% federal.
- 49% perceived county government to be the most fiscally and methodically responsible to its citizens.
- Few were willing to travel much beyond the county for services; transportation is an issue.
- 82% said they would relocate to another community to access services.

Discussion:

- Counties already have a lot of commonality in services.
- Among the 99 counties, there are really only about 6 different county plans that are utilized.
- There are already about five groupings of counties working together in some form.
- Want a local access point where people can get an assessment and find out what service options are available.
- Want face to face contact and place where questions are answered.
- Should we look at a “right” number of consumers rather than population?
- Better to look at general population also because if you look at count of consumers, you may recreate idiosyncrasies of particular areas that have attracted more consumers or where consumers have left because services were not available.
- Goal is to make access equitable everywhere.
- Should we look at capacity and number of providers?

- Need to look at what exists now, but also how capacity can be built where it is lacking.
- Each region will have to have a provider network that offers consumers choice for each of the core services identified by the other workgroups.
- Have both fee for services dollars and program dollars that provide services.
- Program dollars assist a lot of people, but it's not easy to identify how much is spent on which individuals.

Issues:

1. Number of consumers per county/region
2. Number and capacity of providers
3. Dollars tied to people; some tied to services, programs, funding infrastructure
4. Time and distance
5. Set a range for size? Make it flexible within ranges
6. Need to have someone at home base

Range for minimum and maximum size:

- Number that people often use is 300,000.
- In the early days of managed care an actuarial analysis said that a population base of about 300,000 was necessary for risk management.
- The number still tends to get used because of the infrastructure it takes to really establish a system of care.
- Time and distance are big factors for the consumer in determining the size of regions.
- Is there anything wrong with having smaller regions in the west and larger regions in the east?
- A lot of rural counties do not have the services they need available locally now.
- They are already traveling distances to access services.
- The regions should improve that by bringing an array of services into each region.
- Sufficient population to support a structure with satellite offices.
- Be creative with working relationships of the regions.
- Also need to be able to access services between regions when that works best for people.
- Counties that are located on boundaries rely on accessing services in neighboring states.
- There is a difference between standards for the size of the region and what the region has to provide for its people.
- A region can be bigger if there is a network of locally accessible services available to people.
- The size of the region can be invisible to the consumer.
- Lower range of 200,000 population/region?
- Want to make it big enough for the largest population counties like Polk and Linn to be able to join with other counties for mutual benefit.
- Financing will have to follow people if we are to provide equitable access across the state; that's the way Medicaid works.

- It seems some kind of similar mechanism will be needed.
- Don't think it's good for a county to be a region of itself.

Population size:
- 200,000 low end?
- 300,000 mid range?
- Polk County is 430,000
- Upper limit? 700,000?
- Need high enough limit to allow option of Polk and several other smaller counties to join together.

Geographic size:
- Should there be a minimum/maximum number of counties?
- How many counties would you want represented on a board of governance to have it be effective?
- How many is too many?
- Would a 25 member board be effective?
- Would members be willing to travel that far to meet?
- Would distance interfere with true collaboration?

Management:
- Any number of ways you can think about the business aspects of management.
- There has to be a point of accountability.
- Clinical responsibility.
- Program responsibility.
- Fiscal responsibility.
- Must be able to contract with the State.

Service access:
- Where are counties without local services now going to get them?
- Part of this regionalization is to develop services in areas that don't have them; we need to think beyond what we have right now.
- Important providers are at the table with a voice in the governance of the regions.
- Providers would be more stable if they knew they had a catchment area of a given population and an established reimbursement mechanism.
- Could have access to facilities by MOU (Memorandum of Understanding).
- All services would not have to be physically present in the region.
- The State could have waiver capacity to allow that.

Building blocks:
- Have to deal with the reality of Iowa's population distribution from very urban to very rural.
- Does it have to be by county lines?
- Could a community opt out of a region?
- Communities cannot opt out of the county system.
- Would get tremendously complicated if not along county lines.

- Building blocks of regions must be counties.
- Issue of fairness when there is inequality in services and resources.
- Intent of legislature was regions; not a single county being its own region.
- There is benefit in bringing rural and urban counties together.
- Go back to foundational values.
- Formation of regions has to be respectful of what each county has built and protect the integrity of what has been built.

Travel concerns:

- Criteria for travel time/travel convenience?
- Depends on what you need to travel for and how often.
- Travel time can make it difficult to put together citizen's advisory councils, provider councils, etc.
- General rule of thumb for services is 30 minutes or 30 miles for inpatient care; 60 minutes or 60 miles for outpatient care.
- Groups working on core services have to deal with those questions regarding access.

Administration/governance:

- How are administrative functions, appeal issues, etc. affected by geographic location?
- Should there be any upper limit on the number of political subdivisions/counties?
- How do you make a governing board representative without making it too big to function?
- Membership can elect an executive committee to carry out governance functions.
- Can have groups of local advisory committees who elect representatives to a governing board.
- Dollars have to be shared to provide equity.
- Big and small counties should compliment each other by joining together.
- Tension between access to services and pooling county funds between large and small counties.

Summary of consensus recommendations related to criteria for regions:

- Population of 200,000 to 700,000
- Inpatient psychiatric facility
- Access to a community mental health center or federally qualified health center with behavioral services
- Contiguous counties
- No limitation on geographic region/travel time -based on administrative functions
- No limit on number of counties
- 5 to 15 regions; 10 or less is likely
- No less than 3 counties in a region; a single county cannot be a region
- A capacity for the State to grant waivers

NEXT STEPS:

Meeting #3 Agenda:
Carryover items:

- Group discussion of governance options.
    - Functions of regions – how to carry out?
    - Business operations – what should region be expect to do?
- Group discussion of regional service planning.

New items:

- Process for intake, enrollment, service planning and authorization.
- Design a single point of access function for facilities.
- Design civil commitment process at the regional level.
- Referrals and communications with Medicaid.
- Regional interagency and intersystem relationships.
- Members will receive an issue/discussion paper prior to meeting.

MEETING SUMMARY:

Meeting handouts:

- Agenda
- Maps of existing regions and resources
- County population statistics
- County Social Services Financial Report
- County Social Services Service Report
- Northwest Iowa Contracting Consortium Overview
- Southeast Iowa Mental Health and Disability Services Map
- Iowa Department of Aging ADRC information
- Henry County/Southeast Iowa Survey Report

Functions of regions:

- Development of a regional service plan
- Designation of access points
- Service authorization
- Designation of targeted case management
- Contracting with providers/paying providers
- Managing money
- Quality management/quality improvement

Issues:

- Number of consumers per county/region
- Number of and capacity of providers
- Dollars tied to people; dollars tied to services, programs, fund infrastructure
- Time and distance
- Set a range? Make it flexible with in ranges
- Need to have someone at home base

PUBLIC COMMENT:

Comment:	Counties or regions will need to negotiate with other regions. The issue is not how many people your county serves, but where the people being served are living.
Comment:	Northeast Iowa is an anomaly; there are no straight roads and travel simply takes longer. The counties are big. There are parts of the state that are so different; that needs to be taken into account in designing the regions. Transportation is an issue. People often have longer than a two hour drive. If you can reimburse providers in a way that can support satellite offices you can save a lot in transportation cost.
Comment:	With respect to the discussion on the next agenda, would this entity be at financial risk for not performing? If so, what funding source is at risk for not performing? Does that put property tax dollars at risk? If the entity is not assuming risk, then what is the leverage to perform?
DHS Response:	One level of risk is contract compliance and performance; incentives can also be used. Another approach would be similar to the managed care world where the entity must deliver a set of services within the set of dollars they have; if it takes more than that to meet the outcomes, they are at risk for those costs. It is clear that there will be a contractual relationship; the second approach hasn't been discussed yet.
Comment:	How it interfaces with Medicaid managed care is important.
DHS Response:	It would be important to have a strong interface to prevent people from getting passed back and forth between systems.
Comment:	Senate File 525 addresses the issue of access to an inpatient unit and allows for "close proximity" to the region. Hospitals must agree to have a working relationship with the regional entity, but not necessarily within the regional borders.

For more information:

Handouts and meeting information for each workgroup will be made available at: http://www.dhs.state.ia.us/Partners/MHDSRedesign.html

Website information will be updated regularly and meeting agendas, minutes, and handouts for the six redesign workgroups will be posted there.